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Dissemination and Implementation of Evidence Based Treatments for Youth: Challenges and Recommendations

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How can we best facilitate the application of child/adolescent evidence-based treatments (EBTs) in community clinic settings? Many factors have been cited as potential barriers to successful implementation. For example, children treated in community settings tend to have higher comorbidity and greater ecological risks than children treated in university settings. At the provider level, attitudes about EBTs may influence whether or how a therapist chooses to implement the treatment. At the system level, financing constraints on dissemination tools, like training or availability of materials, may be obstacles. We review these factors using the Mental Health System Ecological (MHSE) model and offer recommendations for professional psychologists interested in overcoming these barriers. Our focus for this article is on the child, therapist, and system levels of the MHSE model.

Keywords: evidence-based practice, dissemination and implementation, children's mental health treatment, treatment adaptation

Given the alarming prevalence rates of psychopathology in children (e.g., Hoagwood & Olin, 2002), concerning numbers of children who do not receive adequate treatments (e.g., Tang, Hill, & Boudreau, 2008), and links between childhood and adolescent disorders to adulthood disorders (e.g., Copeland, Shanahan, Costello, & Angold, 2009), there have been extensive efforts to develop and test mental health treatments. These efforts have led to the development of a multitude of what have been called evidence-based treatments (EBTs) for various childhood disorders (e.g., Chorpita et al., 2011). The development and identification of EBTs has been important for the field; however, researchers have recently highlighted some shortcomings of the approach (e.g., Beidas & Kendall, 2010; Schoenwald & Hoagwood, 2001). Most important, evidence to date suggests mixed findings when EBTs are tested in diverse community settings. Some studies have found strong effects for EBTs (e.g., Swenson, Schaeffer, Henggeler, Faldowski, & Mayhew, 2010; Weisz et al., 2012) whereas others have found that EBTs have failed to perform better than usual care (e.g., Clarke et al., 2005; Southam-Gerow et al., 2010).

Treatment programs tend to be developed for a specific child disorder, a focus with significant limitations. Because multiple factors beyond the child's disorder influence how potent a treatment will be, Southam-Gerow, Ringeisen, and Sherrill (2006; cf. Schoenwald & Hoagwood, 2001) outlined a model, the Mental Health Systems Ecological (MHSE) model (see Figure 1), depicting the importance of (a) child and family factors, (b) therapist factors, (c) organization factors, and (d) service system factors. Similar to other approaches (e.g., Damschroder & Hagedorn, 2011; Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005; Proctor et al., 2009), the MHSE model emphasizes the importance of the entire ecology in the adaptation of treatments for dissemination and implementation research. Specifically, the MHSE model posits that a consideration of broader factors (i.e., beyond child symptoms) may lead to more successful dissemination of treatments—and more successful outcomes. For example, child char-

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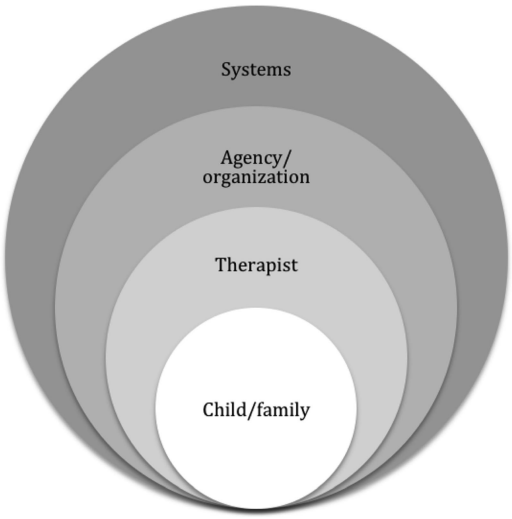

Figure 1. Mental Health Systems Ecological model.

acteristics beyond symptoms and diagnoses (e.g., Southam-Gerow, Chorpita, Miller, & Gleacher, 2008), therapist attitudes toward EBTs (e.g., Aarons, 2004), the culture and climate of a service organization (Glisson et al., 2008), and system-wide policies (e.g., Schoenwald & Hoagwood, 2001) all have a potential influence on how well a treatment will work.

These ecological factors become more salient as EBTs move from the lab into the community, making them particularly relevant for professional psychologists. Due to their unique skill set grounded in science and practice, professional psychologists are often in roles of providing services as well as managing, directing, and/or supervising the dissemination of evidence-based treatments (e.g., Chorpita, 2003). Thus, in this article, we outline some implications of the MHSE model with regard to dissemination and implementation of EBTs in community settings, with an emphasis on the roles that professional psychologists can play in the effort. Specifically, we provide three suggested ways to overcome obstacles posed at three of the four levels of the MHSE model, emphasizing those challenges most relevant to professional psychologists:[1] (a) client/family diversity, (b) therapist training, and (c) systems-level factors.

Child/Family Factors

The MHSE model suggests, and empirical evidence supports (e.g., Baker-Ericzén, Hurlburt, Brookman-Frazee, Jenkins, & Hough, 2010; Ehrenreich-May et al., 2011), the idea that children seen in many community service settings are notably different from children seen in many research clinics, particularly with regard to (a) child comorbidity and (b) child/family diversity (e.g., cultural, socioeconomic status). Although it is not clear from the evidence that these factors will reduce the efficacy of EBTs when disseminated to various service settings, some consideration of how to handle such challenges is warranted. We focus our discussion here on child/family cultural diversity. Important work related to child comorbidity is discussed elsewhere (e.g., Chorpita & Daleiden, 2010; Chu, Merson, Zandberg, & Margaret, 2012; Ehrenreich, Goldstein, Wright, & Barlow, 2009).

One possible concern with the applicability of EBTs across service settings is that most have been tested with primarily Caucasian and middle-class (or higher) families, thus raising the question as to whether or not these treatments will work for other populations without modifications (e.g., Huey & Polo, 2008; Mak, Law, Alvidrez, & Pérez-Stable, 2007). Both child/family minority status and low family income have been associated with premature termination of treatment or attenuation of treatment effects (e.g., Curry et al., 2006; Miller, Southam-Gerow, & Allin, 2008) and with lower levels of child/family engagement in treatment (e.g., Hoagwood et al., 2010; McKay et al., 2004). Thus, therapists working in settings with many diverse children may be hesitant to apply and/or support adoption of EBTs because these approaches have rarely been tested with the children most likely to pose engagement challenges.

Second, even if such engagement challenges were overcome, therapists may question the potency of EBTs across ethnic groups (and across the spectrum of income levels), raising the question of whether or not adaptations to the EBTs are needed. In this section, we focus on the issues of possible adaptations related to child ethnicity. We refer the reader to other sources for a discussion of engagement (e.g., Hoagwood et al., 2010; McKay et al., 2004; Nock & Kazdin, 2001) and adaptations related to family income (e.g., Atkins et al., 2006; Cappella, Frazier, Atkins, Schoenwald, & Glisson, 2008; Lim, Follansbee-Junger, Crawford, & Janicke, 2011).

A relevant question for a therapist to ask about EBTs would be, what (if any) adaptations might be needed when using an EBT with ethnically diverse children? In a meta-analysis of child treatment outcomes studies focused on ethnic minority children, Huey and Polo (2008) offered a few tentative conclusions, tentative because ethnic minorities are underrepresented in the literature. First, they noted that EBTs have been identified for ethnic minority children across a number of problem areas and ethnic groups. However, they noted that no treatment has yet met the *well-established* category as defined by Chambless et al. (1996). Further, they concluded that the evidence was inadequate to demonstrate (a) whether or not EBTs have equivalent, superior, or inferior effects with minority children or (b) whether or not culture-responsive treatments produce better effects. Accordingly, some consideration to cultural adaptations to EBTs is warranted (e.g., Cunningham, Foster, & Henggeler, 2002; Martinez & Eddy, 2005). Although maximizing therapist-client cultural match (see Sue, 1998 for discussion) and adjusting treatments to correspond to cultural beliefs and preferences of diverse families (e.g., Dwight-Johnson, Sherbourne, Liao, & Wells, 2000; Yeh et al., 2005) have been suggested in the literature, we focus here on models for culturally adapting EBTs.

Bernal, Bonilla, and Bellido (1995) outlined several dimensions important for culture-relevant adaptations, including language, content (i.e., cultural knowledge), concepts (i.e., the extent to which concepts in the treatment are consonant with those of the child's culture), and goals, an approach that has been successfully applied (e.g., McCabe & Yeh, 2009; Rosselló, Bernal, & Rivera-Medina, 2008). Domenech-Rodríguez and Wieling (2005) ex-

[1] Note that we do not discuss factors at the organizational level of the model. We refer the reader to other sources for discussion of this important level (Fixsen et al., 2005; Glisson & Schoenwald, 2005).

panded on the Bernal et al. (1995) approach by emphasizing the inclusion of science in the process and integrating stakeholders into the adaptation process. Efforts to apply this model have also found empirical success (e.g., Domenech-Rodríguez, Baumann, & Schwartz, 2011; Nicolas, Arntz, Hirsch, & Schmiedigen, 2009).

Taking a somewhat different tack, Hwang (2006, 2009) outlined two contrasting models for cultural adaptation, the Psychotherapy Adaptation and Modification Framework (PAMF) and the Formative Method for Adapting Psychotherapy (FMAP) model. The PAMF model is a top-down approach (Hwang, 2006), wherein research and other data inform a therapist's approach to cultural adaptation. Some empirical data support the PAMF approach (Wood, Chiu, Hwang, Jacobs, & Ifekwunigwe, 2008). The FMAP is a "community-based, bottom-up approach" (Hwang, 2009, p. 370) wherein community stakeholders are involved in adaptation in a phasic manner (cf. Domenech-Rodríguez & Wieling, 2005). Research using the FMAP is ongoing (Hwang, 2009).

The four models have more in common than not (see Bernal, Jiménez-Chafey, & Domenech-Rodríguez, 2009) and all suggest the importance of considering how culture and ethnicity may influence how a therapist delivers a psychological treatment. However, the question that started this section remains largely unanswered: What, *if any*, adaptations might a therapist need to make to EBTs when working with ethnically diverse children? All four models provide the *how* for adaptation (e.g., adapting language and content to be culturally consonant, seeking stakeholder input about possible adaptations). However, they offer less guidance on the question *whether* to adapt. To address this gap, Lau (2006) proposed a framework for what she calls "selective adaptation" wherein cultural adaptation may be justified when evidence suggests either that (a) differences are present among cultural groups related to important risk or protective factors or (b) outcomes for a treatment differ by cultural group.

Thus, practical guidance for therapists aiming to adapt EBTs for use with diverse clients would include: (a) consideration of whether the literature indicates differential outcomes for youth in the cultural group of their clients, (b) acquisition of knowledge about how risk and protective factors differ across cultural groups, and (c) for situations in which adaptation seems appropriate, understanding of a cultural adaptation model (e.g., Bernal et al., 2009; Domenech-Rodríguez et al., 2011 Hwang, 2009) to help guide adaptation to content (e.g., language, use of concepts) or process (e.g., involvement of family members) in treatment.

However, there are some ethnic/cultural group and problem area combinations (e.g., Native American children with anxiety disorders) for which the evidence may not be adequate to guide clinical decision-making. How then to proceed? A specific example might help. Take a 10-year-old male Latino child client who is referred to the clinic for attentional problems. A search of the evidence reveals only two RCTs for attentional problems have been conducted that included Latino clients (Chorpita et al., 2011). When not constraining the search by ethnicity (i.e., any ethnic group), the number of studies increases to 26 (Chorpita et al., 2011).

In this situation, a therapist has at least three options. First, she could choose to rely on the larger evidence base, arguably a safer option because of the larger evidence base for the problem type, age, and gender of the child, albeit without much data that may apply to the child's ethnic group. Second, the therapist could rely on the smaller evidence base that matched problem type, age, gender, and ethnicity, arguably the more culturally relevant option. A third option, akin to the Lau (2006) approach, might be to make cultural adaptations, based on local knowledge (i.e., stakeholder involvement), to a treatment selected using the one of the first two options. Although any of the three options are defensible, tracking outcomes closely would be an important step to ensure the adapted approach is working.

In short, given the increasingly diverse population of the United States (U.S. Census Bureau, 2010), consideration of the cultural appropriateness of EBTs will continue to be an important focus for therapists, whether in the research or practice domain. Here, we have identified a few concrete steps one could take to help adapt EBTs for use with ethnically/culturally diverse child clients. Next, we turn to how another level in the MHSE model, the provider, may influence the dissemination of EBTs.

Therapist Factors

Although they represent the primary focus of nearly all treatment research to date, differences at the child level are not the only relevant factors. Important differences have been noted between therapists in research studies and those working in the community (e.g., Weisz, Southam-Gerow, Gordis, & Connor-Smith, 2003). For example, therapists in research studies tend to be doctoral students working with the treatment developer who receive intensive training and supervision from the treatment developer (or an expert in the treatment model being tested), and carry small focused caseloads with no productivity quota (i.e., not required to bill a specific number of hours each week). On the other hand, therapists in community settings are a diverse group, representing a large number of professional training backgrounds (psychology, social work, family therapy, counseling, etc.), with varied and usually large caseloads and high productivity demands, and receive considerably less supervision, especially when considered on a minutes-per-case basis.

These differences are important for professional psychologists to consider, whether in the role of a therapist asked to learn a new EBT or in the role of a trainer/supervisor of an EBT. Dissemination of EBTs to community settings will likely require therapist training and the topic of training has become the focus of conceptual and empirical work (e.g., Beidas & Kendall, 2010; Herschell, Kolko, Baumann, & Davis, 2010). A few general guidelines emerge from the literature on therapist training, though the empirical basis of some of the guidelines is not ideal. First, a primary method used to train therapists in treatment models, the workshop approach, has been found ineffective at changing provider behavior in many cases[2] (e.g., Beidas & Kendall, 2010; Grimshaw et al., 2001; Herschell et al., 2010). Most such workshops rely on *passive* training approaches and involve limited if any follow-up after the training day (or days). Thus, the workshop approach alone may not be sufficient for ensuring the application of new and complex behaviors, such as delivering a structured therapy protocol.

What other options exist? Herschell et al. (2010) identified several, including (a) treatment manuals and self-directed train-

[2] Training therapists in a new treatment model is a more complex goal than training them to use a new documentation system, for example. Some training goals are well suited for rather simple training approaches whereas others will require a more complex approach.

ings, (b) intensive workshops (observation and feedback during the training, consultation and/or coaching after), (c) *pyramid training* (i.e., train-the-trainer or cascading), and (d) multicomponent approaches (i.e., combinations of manuals, live trainings, expert consultation, monitoring of taped sessions, and booster training sessions. Herschell et al.'s (2010) review concluded that the multicomponent approach produced superior training outcomes (e.g., improvements in therapist knowledge, acceptable fidelity ratings, child outcomes), though the literature remains a sparse one.

At a more molecular level, Lyon, Stirman, Kerns, and Bruns (2011) identified potentially useful training strategies used in diverse fields (medicine, education). First, they described *academic detailing*, an approach involving *EBT-naïve* therapists requesting that an EBT-trained therapist consult with them in their work settings. In academic detailing, the therapist-in-training provides baseline information about his or her background and knowledge of various practices so that the trainer can create a tailored and efficient training plan, for example by focusing on areas with the largest production (i.e., does not use specific practices) or knowledge (i.e., unfamiliar with specific treatment approaches) gaps. A second approach, *problem-based learning*, combines collaboration and self-directed learning in a unique way. Case examples are generally used as a starting point, with the trainer and trainees working collaboratively to (a) analyze the problem (e.g., how to devise a treatment plan for the case); (b) identify and justify possible solutions, sometimes requiring acquisition of new knowledge; (c) select a solution and take the necessary steps to enact the plan; and (d) report outcomes back to the group. One relevant aspect of this approach for dissemination of EBTs is the direct encouragement of trainees to identify and address knowledge gaps to solve problems. Finally, Lyon et al. (2011) described *coaching*, (by expert or peer), as an approach that follows formal training. Expert coaching "involves a person with expertise in the content . . . providing direct feedback and advice" (Lyon et al., 2011, p. 246). Peer coaching is when peers, for example two therapists, give each other constructive feedback aimed at improving performance in a particular domain (e.g., providing therapy, teaching).

A training "how-to" literature is emerging and will be a good guide for professional psychologists who find themselves in the role of trainer and/or supervisor of other providers learning EBTs. Before setting the training date, however, Beidas and Kendall (2010) cautioned that a consideration of the complex systems in which therapists are embedded is needed before identifying a method for training (cf. MHSE model). Specifically, they noted that training efforts will be influenced by therapist variables, including basic demographic characteristics (e.g., gender, race), previous training background, theoretical orientation, professional guild, and therapist attitudes toward EBTs. Several studies affirm the importance of considering such therapist characteristics. For example, several studies have found that many therapists do not view EBTs favorably for a variety of reasons such as rigidity of treatment manual (e.g., Aarons, 2004; Brookman-Frazee, Garland, Taylor, & Zoffness, 2009; Jensen-Doss, Hawley, Lopez, & Osterberg, 2009). Multiple factors have been investigated as potential moderators of therapist attitudes, including *knowledge of EBTs* (positively related to attitudes), *formal education level* (mixed evidence), and therapist experience (no relation to attitudes; e.g., Jensen-Doss et al., 2009; Nakamura, Higa-McMillan, Okamura, & Shimabukuro, 2011).

Thus, a few tentative suggestions emerge for the professional psychologist tasked with training therapists in an EBT. First, know the audience; survey the trainees on their background, knowledge, and attitudes about EBTs. Second, if possible, increase therapist knowledge about EBTs *prior* to training, thereby potentially improving attitudes toward EBTs and thus, facilitate training efforts. When therapists are trained in EBTs, studies suggest that their attitudes toward EBTs improve, though the effect may be specific to the EBT being trained and time limited (e.g., Borntrager, Chorpita, Higa, & Weisz, 2009; Jensen-Doss et al., 2008). Further, more evidence is needed on whether or not training leads to increases in actual behavior (Lopez, Osterberg, Jensen-Doss, & Rae, 2011).

Although professional psychologists may find themselves in the role of trainee as EBTs are disseminated, more likely they will be in the role of trainer and/or supervisor. For such psychologists, Decker, Jameson, and Naugle (2011) enumerated a set of relevant outcomes related to therapist training that could be used. For example, measures of therapist perceptions of the training itself are needed. Further, changes in therapist attitudes should be assessed over time. As well, knowledge and skills, via self-report and/or observation (e.g., coding), should be monitored. At this point, our science related to treatments far outpaces our science related to training. As such, professional psychologists are likely to play an important role in the future of dissemination and implementation research.

In this section, we described the importance of therapist training for dissemination of EBTs, highlighting action steps for professional psychologists, including desirable aspects of therapist training models and important variables to measure when training therapists. Next, we turn to the last of the factors thought to influence dissemination efforts: mental health systems.

Systems Factors

Professional psychologists more and more find themselves in managerial, directorial, and/or administrative roles in behavioral health organizations. Accordingly, awareness of and attention to the system level of the MHSE model (e.g., federal, state, and local polices, insurance companies policies) is becoming increasingly important. When considering support for the dissemination of EBTs at the system level, numerous interacting factors become important to consider. In this section, we highlight several of the concrete issues that may be faced by professional psychologists when implementing EBTs in child-serving systems. Specifically, we describe the importance of (a) coordinating clinical and administrative functions; (b) credentialing; (c) system constraints (e.g., documentation standards, requirements); and (d) quality monitoring efforts.

An overarching distinction that often pervades current systems is the division between *clinical services* and *administrative operations*. Common *clinical service* functions include: (a) direct care, (b) supervision, and (c) clinical support (e.g., scheduling, documentation, etc.). Common *administrative* functions include (a) governance and planning, (b) policy and standard setting, (c) utilization management (UM), (d) performance or quality management, (e) credentialing, (f) finance and business development, (g) workforce development, and (h) network relations (e.g., provider relations, customer relations, public relations, etc.). In addition, as

a strategy for coordinating services across multiple system or stakeholder groups, case management or care coordination is often provided as a customer service that may straddle the line of clinical and administrative services (e.g., aligning clinical and administrative resources).

Each of these functions may either support or inhibit the use of EBTs in a system. Pursuit of a large-scale systematic implementation of EBTs may call for comprehensive consideration of these functions. When an EBT is implemented in the context of an operating system, clinical and administrative functions are often encountered as constraints on the implementation. For example, if a team of providers would like to adopt a new practice, without a system level financing intervention, a defined set of billing codes may need to be mapped to the components of the new practice (e.g., an office visit code will be used for child session, a planning or consultation code will be used for a teacher session, collateral or family code will be used for a parent session, room and board will be billed to a different funding agency). On the other hand, system administrators seeking to implement such a program may consider whether financing could be restructured to allow a bundled rate or whether provider contracts could be established under a cost-reimbursement—rather than unit-rate structure. At a minimum, professional psychologists need to be aware of the importance of administrative and clinical service collaboration to facilitate changes in the system, including especially implementation of a new EBT. By working together to identify potential problems and fashion solutions leveraging their unique expertise in the system, therapists and administrators (both roles of professional psychologists) will enhance the likelihood of the success of the dissemination efforts.

Credentialing, that is tracking adherence to predefined standards for the workforce (e.g., licensure, certification), may also play a key role in EBT implementation and may be a function that therapists need to perform. System level credentialing varies widely, and decisions about how broad or narrow to set credentialing requirement have huge implications for practice implementation. Professional licensing standards are among the broadest credentialing requirements. The types of licenses approved vary by state, meaning that systems must manage and have regulations for a host of professionals. Furthermore, the types of services that may be delivered by licensed, unlicensed but supervised, unlicensed professionals, or paraprofessionals vary widely. Specific to EBTs, there is no current standard for the credentialing of providers in the delivery of specific EBTs. Although many EBTs have developed specific standards for providers to be certified or approved to provide the EBT, those standards differ by EBT. And many EBTs have no standards at all. Systems may also set their own credentialing requirements, for example requiring model-specific certification by EBT developers to qualify for reimbursement or may set performance standards requiring that a defined proportion of services be delivered by providers with model-specific certifications. Given the complexity within the service system, professional psychologists involved in dissemination and implementation efforts will need to be familiar with credentialing.

Numerous other system policies and standards may support or inhibit EBT implementation and professional psychologists involved in dissemination of EBTs will need to not only be aware of these but be prepared to take steps to create policies and standards that will support EBTs. Although supervision requirements are increasingly common in child serving systems, EBT implementation may be facilitated or inhibited by the extent that the nature and volume of supervision required is consistent with the supervision framework for that EBT model. If multiple EBT models have different supervision requirements, tough decisions about balancing model adherence, productivity, and financial benefit may be required; these are exactly the sorts of decisions that professional psychologists will face as the clinical director, for example, of an agency attempting to implement an EBT.

Finally, caseload requirements and/or market pressures that drive caseload size may also be relevant to EBT implementation. Proper implementation of some EBTs includes a defined caseload limit, whereas others may provide guidelines, and still others remain silent on the issue. The extent to which the prescribed caseload limits fit (or not) within a particular system is obviously a key issue. The dissemination literature has suggested that one of the factors affecting the ability to effectively implement organizational change is the availability of "slack" resources to dedicate toward new initiatives (Fixsen et al., 2005; Greenhalgh, Robert, MacFarlane, Bate, & Kyriakidou, 2004). Caseload burden may be one indicator of resource demands, and a common complaint of therapists is that there may not be "enough time" to manage existing caseloads (Hamilton, Daleiden, & Dopson, 2011) much less tolerate a period of reduced productivity during adoption of a new clinical model. Again, therapists acting as the lead in a dissemination effort will need to consider how to manage caseload throughout that effort, perhaps balancing the needs of therapists for lighter caseloads while learning a new approach with the needs of the agency for productivity to maintain fiscal soundness.

The last system-level consideration is related to the definition of quality and the relative priority assigned to managing performance in systems. One common approach to defining quality is to emphasize the *access* and *availability* of services. Although this approach may help increase penetration of services and reduce unmet need, it may have a deleterious effect on the implementation of EBTs by narrowing organizational focus and increasing productivity pressures without a counterbalancing quality/integrity pressure (Hamilton et al., 2011). That is, emphasis on the quantity of services over the quality of those services runs the risk of poorer child outcomes and poorer therapist morale (Hamilton et al., 2011). Alternatively, defining quality in terms of maintaining fidelity to EBTs may contribute to more favorable outcomes (e.g., Hogue et al., 2008; Schoenwald, Sheidow, & Chapman, 2009), though such an approach may increase costs for the agency through the need to monitor fidelity. Again, given their unique skill set including knowledge of treatments and knowledge of scientific methods, professional psychologists may find themselves tasked with creating quality and performance measurement tools to help a system measure and improve the quality of services delivered.

For professional psychologists whose primary focus is provision of direct services in agencies or systems, knowledge of these systems-level factors may help them to collaborate more effectively in dissemination efforts. For those professional psychologists in mixed or primarily administrative roles, however, these factors are even more important. By taking the right steps, a psychologist can guide an organization in a planful manner, aligning administrative and clinical functions to maximize the impact of an EBT initiative. For example, one can work to identify the

administrative barriers to implementation in advance, providing time to generate the processes needed to reduce or eliminate those barriers. Indeed, the overall focus of the article—that consideration of the whole of the MHSE model may be needed to enact maximum impact of dissemination efforts—is itself a systems-level intervention. And psychologists are uniquely suited for the task ahead. By training, we take a broad and ecological view of intervention. Doing so when disseminating EBTs, then, could come to us naturally.

Summary

The challenges of bridging the science-practice gap in children's mental health led to the elaboration of a field of inquiry, dissemination and implementation science. One focus of this work has been on identifying barriers to dissemination and how to overcome them. In this article, we outlined the Mental Health Service Ecological (MHSE) model as a framework for understanding some of these barriers. We then described proposed solutions at the three of the levels of the MHSE model. The development and testing of child/adolescent EBTs will require a focus across multiple levels of the ecology to maximize the public health impact of clinical science. We must grapple with how to address and account for child, therapist, and system differences related to the delivery of therapies for childhood emotional and behavioral problems. Although some directions were identified in this review article, we are hopeful that the growing legions of psychologists and other scientists whose focus is on dissemination and implementation research will continue to push the envelope to accomplish the goal of identifying how to deliver the best services to the most children and families.

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